CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
TABLE OF CONTENTS

CHAPTER V
BILLING INSTRUCTIONS

INTRODUCTION

The State/Local Hospitalization (SLH) Program uses the UB-92 CMS-1450 (UB-92) billing form for all claims for inpatient and outpatient hospital services, including hospital outpatient ambulatory services and all ambulatory surgical centers. Claims submitted for these services on a form other than the UB-92 CMS-1450 form will be returned to the provider. The data elements and design of the form were determined by the National Uniform Billing Committee. However, a State Uniform Billing Committee (SUBC) was established to define state level codes and fields and for implementing the UB-92 claim form throughout Virginia.

The SUBC prepared a training manual to assist providers and payers in the proper implementation of the UB-92 as well as to guide those responsible for claims preparation and processing. While the manual was designed to accommodate Virginia's unique needs, it does not contain certain information which SLH inpatient and outpatient hospital providers must have to properly utilize the UB-92. This chapter provides a condensed outline of UB-92 billing requirements and includes supplementary SLH information that is critical for purposes of billing the SLH Program. Claims for inpatient and outpatient hospital services must be submitted on the UB-92 CMS-1450 billing invoice using the appropriate billing codes.

The SLH Program uses the CMS-1500 (12-90) claim form for all health department claims. Claims submitted for services provided by the health department on a form other than the CMS-1500 (12-90) will be returned to the provider. This chapter also provides a condensed outline of the CMS-1500 (12-90) billing requirements and includes supplementary SLH information that is critical for billing the SLH Program for health department claims. Claims for health departments must be submitted on the CMS-1500 (12-90) billing invoice using the appropriate billing codes.

DMAS will not accept photocopies or laser-printed copies of the UB-92 CMS-1450 and CMS-1500 (12-90) claim forms. The requirement to submit claims on an original CMS-1500 (12-90) and UB-92 CMS-1450 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of the form. These statements become part of the original billing invoice.

CLAIMS SUBMISSION

The SLH Program regulations require the prompt submission of all claims. The provider must submit all claims within 30 days of the last day of service or 30 days from the notice of eligibility or 30 days from the receipt of the primary carrier's payment notice, whichever is later, but in no case will payment be made for claims submitted 45 days after the close of the SLH payment year (April 30) for services rendered in the prior SLH payment year.

Mail completed claim forms to:

Department of Medical Assistance Services
State/Local Hospitalization Program
P.O. Box 27443
Richmond, Virginia 23261-7443

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit SLH claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information, contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741
Fax number: (804) 273-6797

First Health's website: http://virginia.fhsc.com
Email: edivmap@fhsc.com

Mailing Address

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

Electronic Billing Attachment Form

A new attachment form (DMAS-3) will be available for use by electronic billers **only** to submit a non-electronic attachment to an electronically-submitted claim. An Attachment Control Number (ACN) must be entered on the electronic claim submitted. The ACN consists of the combined fields of the patient account number, date of service, and the sequence number. (See the First Health Services Corporation website at http://virginia.fhsc.com/ for electronic claim transmission specifications).

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM, OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, THE CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS, OR THE CLAIM MAY RESULT IN A DENIAL. A sample of the new form is included in the "Exhibits" section. Copies of the DMAS-3 may be downloaded from the DMAS website at www.dmas.virginia.gov (***please note the new DMAS website address***).

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia SLH is mandated by state regulations to require the initial submission of all claims (including accident cases) within 30 days from the last date of service or notice of eligibility. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments (See Exhibits). SLH is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - SLH eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to SLH the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

- **Denied Claims** - Denied claims submitted initially within the current SLH fiscal year may be resubmitted and considered for payment without prior approval from SLH. The procedures for resubmission are:

  - Complete the appropriate invoice as explained in this chapter.

  - **Attach** written documentation to verify the explanation. This documentation may be denials by SLH or any follow-up correspondence from SLH showing that the claim was submitted to SLH initially within the required 12-month period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See Exhibits).

  - For the CMS-1500 form indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.

  - Submit the claim in the usual manner by mailing the claim to:

    Department of Medical Assistance Services
    Practitioner
    P.O. Box 27443
    Richmond, Virginia 23261-7443

    The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill SLH or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to SLH the fiscal year in which the service occurred. If the provider waits for the settlement before billing SLH and the wait extends beyond the current fiscal year, no reimbursement can be made by SLH as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to SLH within the fiscal year in which services occurred.** If the provider waits for payment before billing SLH and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by SLH as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from SLH has been made, an adjustment or void should be filed at that time.

INQUIRIES

A toll-free "HELPLINE" is available to assist providers in interpreting State/Local Hospitalization Program policy and procedures and in resolving problems with individual claims. If assistance is needed, call the DMAS Provider "HELPLINE" number:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

The Provider "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State Holidays.

REPLENISHMENT OF BILLING MATERIALS

Hospitals must purchase the UB-92 and CMS-1500 form. The Virginia Health Care and Hospital Association has a group purchasing plan, or the provider can check with the vendor of his or her choice. The UB-92 and the CMS-1500 (12-90) Health Insurance Claim Form are available from forms printers and the U.S. Government Printing Office. Specific details on purchasing both forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia SLH payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia SLH policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that SLH comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800) 924-6741.

THIRD-PARTY PAYERS

The Insurance Information Section of the SLH Client Notification Form provides information on other carriers that must be billed before SLH. The Virginia SLH Program has secondary liability for its beneficiaries to all other third-party carriers, including the VA Medicaid Program. Providers must bill other sources before payment is requested from the SLH Program.

PAYMENT BASIS

Chapter 782 of the *1996 Virginia Acts of Assembly* required the Department of Medical Assistance Services to conform the SLH hospital claims reimbursement rate methodology to the inpatient hospital reimbursement rate methodology for the SLH Program. Chapter 912 of the *1996 Virginia Acts of Assembly* also required the Board of Medical Assistance Services to implement a fully prospective reimbursement system for inpatient hospital services based on a Diagnosis Related Groups (DRG) methodology. Therefore, the SLH reimbursement methodology was amended to conform with the DRG methodology, which will be implemented with claims submitted to DMAS with an admission date on or after June 20, 2003.

The basis for payment for hospital outpatient clinic services will be the current SLH allowance for an intermediate office visit for an established patient and is an all inclusive payment.

The basis for payment for hospital emergency room services will be the current SLH allowance for an intermediate level, emergency department visit, for an established patient and is an all inclusive payment.

The SLH payment for health department visits is based on the current SLH allowance for an intermediate office visit and is an all inclusive rate per visit.

The SLH payment for either free-standing or hospital-based ambulatory surgical procedures is based on the current SLH allowance for the ambulatory surgery groups established by Medicare for the primary surgical procedure performed.

Local departments of social services are not required to continue taking SLH applications for **dates of service** on or after November 1 of any year if locality funds are exhausted. This means that providers of services are no longer required to bill for dates of service on or after November 1 of each year if locality funds are exhausted. However, providers must bill for covered medical services with dates of services through October 31, even if the locality's SLH funds are exhausted. DMAS tracks paid and unpaid covered SLH services with dates of service through October of each year to estimate the medical need for each locality, which is a determining factor in how much of the State's SLH funding will be allocated to the locality.

NOTE: Payment by SLH is contingent upon the current availability of funds.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will no longer be accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

UB-92 BILLING INSTRUCTIONS FOR HOSPITAL INPATIENT/OUTPATIENT SERVICES

The following description outlines the process for completing the UB-92 CMS-1450 for inpatient or outpatient hospital care. It includes SLH-specific information and must be used to supplement the material included in the *State UB-92 Manual*. Do not include charges for outpatient clinic or emergency room services with charges for inpatient hospital care except when the patient is admitted from the emergency room.

Instructions for Completing the UB-92 CMS-1450 Universal Claim Form

The UB-92 CMS-1450 is a universally accepted claim form that is required when billing the Department of Medical Assistance Services (DMAS) for covered services. This form is readily available from commercial printers. DMAS **will not** provide the UB-92 CMS-1450. (See "Exhibits" section for a sample UB-92 CMS-1450 form).

General Information

The following billing instructions apply to the State and Local Hospitalization (SLH) Program within its scope of covered services. Instructions, which pertain to SLH generally apply to the SLH Program unless otherwise indicated.

- All dates used on the UB-92 CMS-1450 must be two digits each for the day, the month, and the year (e.g., 010198) with the exception of Locator 14, Patient Birthdate, which requires four digits for the year (1998).

  NOTE: NO SLASHES, DASHES, OR SPACES.

- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

- Do not record cost reduction copayments on this form.

- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point.

- The professional fee is not a reportable item on the UB-92 CMS-1450 for general hospital inpatient or outpatient services.

Following is the process for completing the UB-92 CMS-1450. It includes SLH-specific information and must be used to supplement the material included in the *State UB-92 Manual*.

Locator	Instructions	
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required (if applicable)**	**PATIENT CONTROL NO.**—SLH will accept an account number, which does not exceed 17 alpha-numeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Valid codes for Virginia SLH are: 111 Original Inpatient Hospital Invoice 112 Interim Inpatient Hospital Claim Form* 113 Continuing Inpatient Hospital Claim Invoice* 114 Last Inpatient Hospital Claim Invoice* 117 Adjustment Inpatient Hospital Invoice 118 Void Inpatient Hospital Invoice 131 Original Outpatient Invoice 137 Adjustment Outpatient Invoice 138 Void Outpatient Invoice * The proper use of these codes (see the *State UB-92 Manual*) will enable DMAS to reassemble cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement on claims.
5	Not required	FED. TAX NO.
6	**Required**	**STATEMENT COVERS PERIOD**—Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day with the discharge status of 01. For inpatient hospitalization claims received on or after June 1, 2003, the billing cycle for general medical surgical services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Psychiatric services for adults remains limited to the 21 days. Interim claims (bill

Locator	Instructions	
		types 112 or 113) submitted with less than 120 day will be denied. Bill type 111 or 114 submitted with greater than 120 days will be denied. Claims for psychiatric services submitted which exceed the 21-day limitation for adults will be denied, "Limit of 21 Days Per Billing Invoice Exceeded." The billing period may overlap calendar months. For inpatient hospitalization, when the enrollee has a change in benefit program (SLH to Medicaid) the claim with the appropriate dates of service must be billed as interim claims (e.g. hospitalization = 7/30/03 through 9/05/03. Enrollee eligible for SLH 7/01/03 through 7/31/03 and eligible for Medicaid 8/01/03 through 9/05/03. Claims would be billed 7/1/03 through 7/31/03 (31 days); Bill type 112 and discharge status of 30; 8/01/03 through 9/05/03 (35 days); Bill type 114, and discharge status of 01. The appropriate charges would be applied to each interim claim. This is the only situation that DMAS will allow the bill type 112 to be less than 120 days).
7	**Required**	**COV D. (Covered Days)**—Enter the total number of SLH covered days as applicable. This must be the total number of covered accommodation days/units reported in Locator 46. For outpatient services, this is the number of visits.
8	**Required**	**N-CD. (Non-Covered Days)**—Enter the days of care not covered for inpatient only. Do not include non-covered days in covered days.
9	Not required	C-ID. (Co-Insurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	Unlabeled Field	
12	**Required**	**PATIENT NAME**—Enter the patient's name—last, first, middle initial.
13	**Required**	**PATIENT ADDRESS**—Enter the patient's address.
14	**Required**	**BIRTHDATE**—Enter the month, date, and full year (MMDDYYYY).

Locator	Instructions	
15	**Required**	**SEX**—Enter the sex of the patient.
16	**Optional**	**MS (Patient's Marital Status)**
17	**Required**	**DATE (Admission Date)**—Enter the date of admission for inpatient. Enter the date of service for outpatient. For inpatient interim (bill types 112, 113 or 114) claims, the admission date is to remain the same for all interim claims.
18	**Required**	**HR (Admission Hour)**—Enter the hour during which the patient was admitted for inpatient or outpatient care.
19	**Required**	**TYPE (Type of Admission)**—For inpatient services only, enter the appropriate code indicating the priority of this admission.
20	**Required**	**SRC (Source of Admission)**—Enter the appropriate code for the source of this admission.
21	**Required**	**D HR (Discharge Hour)**—Enter the hour the patient was discharged from inpatient care.
22	**Required**	**STAT (Patient Status)**—Enter the status code as of the ending date in Statement Covers Period (Locator 6). CHANGE Enter the status code as of the ending date in Statement Covers Period (Locator 6). (If the patient was a one-day stay, enter code "01".) Correct reporting of the patient status code will facilitate quick and accurate determination of DRG reimbursement. In particular, accurate reporting of the values 01, 02, 05, and 30 will be very important in a DRG methodology.
23	**Required (if applicable)**	**MEDICAL RECORD NO.**—Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: Do not substitute this number for the Patient Control Number (Loc. 3) assigned by the provider to facilitate retrieval of the individual financial record.
24-30	**Required (if applicable)**	**CONDITION CODES**—Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer

Locator	Instructions	
		processing. Refer to the SUBC manual for complete listing of these codes. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES**—Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. Refer to the SUBC manual for complete list.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES**—Enter the code(s) and related dates that identify an event relating to the payment of this claim. Refer to the SUBC manual for complete list. If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital stay that ended within 60 days of this hospital admission.
37	a-c Not Required	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine to 16 digit claim reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). Be sure to use the appropriate type of bill (Locator 4) in combination with the reference number from the incorrect claim. NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross-Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	**RESPONSIBLE PARTY NAME AND ADDRESS**

Locator	Instructions	
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim One of the following codes must be used: 82—No Other Coverage 83—Billed and Paid 85—Billed and Not Paid
42	**Required**	**REV. CD. (Revenue Codes)**—Enter the appropriate revenue code(s), which identify a specific accommodation, ancillary service, or billing calculation. **Code = 4 digits, right justified, leading zero, if applicable.**
43	**Required**	**DESCRIPTION**—Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the *State UB-92 Manual*).
44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Center there must be the surgical CPT code on the same line as revenue code 0490.
45	**Required (if applicable)**	**SERV. DATE**—Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or auxiliary units of service where appropriate.
47	**Required**	**TOTAL CHARGES (by Revenue Codes)**—Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. **Note:** Use code "0001" for TOTAL.
48	**Optional**	**NON-COVERED CHARGES**—Reflects non-covered charges for the primary payer pertaining to the related revenue code.

Locator	Instructions	
		Note: Use revenue code "0001" for TOTAL Non-Covered Charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C Required**	**PAYER**—Identifies each payer organization from which the provider may expect some payment for the bill. A = Enter the primary payer. B = Enter the secondary payer if applicable. C = Enter the tertiary payer if applicable. When SLH is the only payer, enter "SLH" on Line A. If SLH is the secondary or tertiary payer, enter on Lines B or C.
51	**A-C Required**	**PROVIDER NO.**—The SLH Provider ID # is the **same as the Medicaid Provider ID**#. Enter this number on the appropriate line**.** A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information—Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits—Certification Indicator)
54	**A, B, C, P Required (if applicable)**	**PRIOR PAYMENTS (Payers and Patients)** **Note:** A = Primary B = Secondary C = Tertiary P = Due from Patient
55	Not Required A, B, C	PAST AMOUNT DUE
56	Unlabeled Field	
57	Unlabeled Field	

Locator	Instructions	
58	**A-C Required**	**INSURED'S NAME**—Enter the name of the insured person covered by the payer in Locator 50. The name on the SLH line must correspond with the name on the SLH ID card. If the patient is covered by insurance other than SLH, the name must be the same as on the patient's health insurance card. Enter the insured's name used by the primary payer identified on Line A, Locator 50. Enter the insured's name used by the secondary payer identified on Line B, Locator 50. Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL**—Enter the code indicating the relationship to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT.-SSN-HIC.-ID NO.**—For lines A-C, enter the unique SLH identification number assigned by the local department of social services to the recipient identified on lines A-C, Locator 58.
61	**A-C Required (if applicable)**	**GROUP NAME**—Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable**)	**INSURANCE GROUP NO.**—Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	A-C Not Required	TREATMENT AUTHORIZATION CODES—Enter the number indicating that the treatment is authorized by the payer.
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)**—Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME**—Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.

Locator	Instructions	
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION**—Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD.**—Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)**—Enter the codes for diagnoses other than principal if applicable. **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.**—Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician.
77	**Required (if applicable)**	E-CODE (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)**—Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 - HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**PRINCIPAL PROCEDURE CODE AND DATE**—Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** For outpatient ambulatory surgical center claims, a CPT procedure code must appear on the same line as the revenue code 0490 in Locator 42 or the claim will be denied.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE—**The ICD-9-CM procedure codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Locator		Instructions
82	**Required**	**ATTENDING PHYS. ID—** Inpatient: Enter the number assigned by SLH for the physician attending the patient. Outpatient: Enter the number assigned by SLH for the physician who performs the principal procedure. Note: Physicians are not enrolled in SLH. If the attending physician is not a SLH or Medicaid provider, use 99-9999-9.
83	**Required (if applicable)**	**OTHER PHYSICIAN ID—**The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.
84	**Required (if applicable)**	**REMARKS-**Providers may indicate the ICN# of a prior submitted claim that would contain the medical records that would assist with this claims processing.
85	**Required**	**PROVIDER REPRESENTATIVE**—Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. Required for paper claims only.
86	**Required**	**DATE**—Enter the date on which the bill is submitted to SLH.

Mail the original claim with any attachments for consideration of payment to:

Department of Medical Assistance Services
State/Local Hospitalization Program
P.O. Box 27443
Richmond, Virginia 23261-7443

Maintain a copy in the provider's files for future reference.

Hospital Outpatient Services

Complete the UB-92 CMS-1450 in the usual manner for outpatient services. The following SLH-specific information supplements the material included in the *State UB-92 Manual*. Hospital outpatient services cannot be billed with hospital inpatient services.

Type of Bill (Locator 4)

Enter the appropriate type of billing code:

131 Original Outpatient Invoice
137 Adjustment Outpatient Invoice
138 Void Outpatient Invoice

COV. D. (Locator 7)

Enter the number of outpatient visits during the period "FROM" and "THROUGH" shown in Locator 22.

Revenue Code (Locator 42)

Enter the revenue code for the type of outpatient hospital visit being billed: These are the only revenue code allowed for SLH outpatient hospital claims.

0450 Hospital Emergency Room
0510 Hospital Outpatient Clinic

Description (Locator 43)

Enter the description of the revenue code for the type of clinic visit being billed:

Hospital Emergency Room
Hospital Outpatient Clinic

SLH Provider Number (Locator 51)

The SLH Provider ID # is the **same as the Medicaid Provider ID #.**

Cert.-SSN-HIC-ID No. (Locator 60)

Enter the 12-digit SLH eligibility number shown on the Client Information Form.

Provider Representative X

Enter the signature of the provider representative completing the invoice.

Mail the original claim with any attachments for consideration of payment to:

Department of Medical Assistance Services
State/Local Hospitalization Program
P.O. Box 27443
Richmond, VA 23261-7443

Maintain a copy in the provider's files for future reference.

UB-92 (CMS-1450) ADJUSTMENT AND VOID INVOICES

- To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges.
  - Type of Bill (Locator 4) - Enter code 117 for inpatient hospital services or enter code 137 for outpatient services.
  - Locator 37 - Enter the nine to sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.
  - Remarks (Locator 84) - Enter an explanation for the adjustment.

  NOTE: Inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

  - Admission Date
  - From or Through Date
  - Discharge Status
  - Diagnosis Code(s)
  - Procedure Code(s)
- To void a previously paid claim, complete the following data elements on the UB-92 CMS-1450:
  - Type of Bill (Locator 4) - Enter code 118 for inpatient hospital services or enter code 138 for outpatient hospital services.
  - ICN/DCN (Locator 37) - Enter the nine to sixteen digit claim reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.

AMBULATORY SURGERY CENTERS

The facility fee for the use of the Ambulatory Surgery Center (ASC) should be billed by using the Current Procedural Terminology (CPT) code that describes the surgery that was performed. SLH is using the most recent ASC group listings as defined by Medicare. For the most recent listings, see the Medicare website (www.cms.gov). If you are billing for a procedure that is not included in these listings, your claim will pend for reason 749 and will be manually reviewed for payment. Remember that the fee that is reimbursed to ASCs

is for the use of the facility only. The reimbursement rate for facilities is based on fees established by DMAS.

Your payment will be determined based on the ASC Group that the procedure falls in. See crosswalk chart below:

Crosswalk from Previous "M" Codes to ASC Group Listings

Old Code	ASC Group	Payment to Facility
M0050	Group 1	$277.44
M0051	Group 2	$371.52
M0052	Group 3	$426.05
M0053	Group 4	$524.83
M0054 (formerly used as an unlisted code for surgeries not found in other ASC Groups)	Group 5	$599.14
No previous code	Group 7	$869.14

*Note: Medicare has established a payment rate for ASC Group 6 but at the present time, there are no procedures that fall under this group; therefore, SLH has not established a rate.

**Note: The conversion from the "M" Codes to the specific CPT Code is effective for services provided on or after June 20, 2003.

Multiple Surgeries Performed in ASCs

If you are billing for two or more surgeries performed on the same day, you will be paid 100 percent for the surgery with the higher payment level and 50 percent of the payment level for any additional surgeries.

BILLING INSTRUCTIONS FOR AMBULATORY SURGICAL CENTERS

Complete the UB-92 CMS-1450 Invoice in the usual manner for outpatient services. The following SLH-specific instruction supplements the material included in the *State UB-92 Manual* for surgery performed in a hospital ambulatory suite.

Type of Bill (Locator 4)

Enter the appropriate code:

131 Original Outpatient Invoice
137 Adjustment Outpatient Invoice
138 Void Outpatient Invoice

Cov. D (Locator 7)

Enter the number of ambulatory surgical encounters during the "FROM" and "THROUGH" period shown in locator 22.

Revenue Code (Locator 42)

Enter the revenue code for Hospital Ambulatory Surgical Suite.
Note: A CPT code must be on same line as this revenue code in locator 44

0490 Hospital Ambulatory Surgical Suite

Description (Locator 43)

Enter the description of the revenue code for ambulatory surgery.

Ambulatory Hospital Surgery Suite

Locator 44 (Required)

HCPCS/Rates Enter the CPT code on the same line as the 0490 revenue code. This will allow the correct ASC Group to be calculated for reimbursement.

SLH Provider Number (Locator 51)

The SLH Provider ID # is the **same as the Medicaid Provider ID**#.

Cert.-SSN-HIC-ID No. (Locator 60)

Enter the 12-digit SLH eligibility number shown on the SLH Client Notification Form.

Procedure Code (Locator 80)

Enter the appropriate HCPCS procedure code.

Provider Representative X

Enter the signature of the provider representative completing the invoice.

Mail the original claim with any attachments for consideration of payment to:

Department of Medical Assistance Services
State/Local Hospitalization Program
P.O. Box 27443
Richmond, VA 23261-7443

Maintain a copy in the provider's files for future reference.

CMS-1500 (12-90) BILLING INSTRUCTIONS FOR HEALTH DEPARTMENTS

The following description outlines the process for completing the CMS-1500 (12-90) for outpatient clinic services performed by participating local health departments. The SLH Program regulations require prompt submission of all claims. The provider shall submit all claims within 30 days of the last day of service or 30 days from the notice of eligibility or 30 days from the receipt of the primary carrier's payment notification, whichever is later, but in no case will payment be made for claims submitted more than 45 days after the close of the SLH payment year (April 30) for services rendered in the prior SLH payment year.

Health Department Services

The SLH Program provides for certain outpatient clinic services by a participating local health department. These services include:

- Family Planning;
- General Medicine;
- Well-Child Services;
- Maternity Care; and
- Gynecological Services

General Information

The SLH payment for health department visits is based on the current SLH allowance for an intermediate office visit and is an all inclusive rate per visit and is billed as:

Code	Description of Services
99214	Health Department Visits

NOTE: Payment by SLH is contingent upon the current availability of funds.

BILLING INSTRUCTIONS FOR THE CMS-1500 (12-90) CLAIM FORM

Locator		Instructions
1a	**Required**	**Insured's ID Number—Enter the 11- or 12-digit identification number for the SLH Client receiving the service.**
2	**Required**	**Patient's Name—Enter the name of the enrollee receiving the service.**
3	Not Required	Patient's Birth Date
4	**Required**	**Insured's Name**
5	Not Required	Patient's Address
6	Not Required	Patient Relationship to Insured
7	Not Required	Insured's Address
8	Not Required	Patient Status
9	Not Required	Other Insured's Name
9a	Not Required	Other Insured's Policy or Group Number
9b	Not Required	Other Insured's Date of Birth and Sex
9c	Not Required	Employer's Name or School Name
9d	Not Required	Insurance Plan Name or Program Name
10	**Required**	**Is Patient's Condition Related To:—Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c: Other Accident? (This includes schools, stores, assaults, etc.)**
10d	Not Required	Reserved for Local Use
11	Not Required	Insured's Policy Number
11a	Not Required	Insured's Date of Birth
11c	Not Required	Insurance Plan or Program Name
11d	Not Required	Is There Another Health Benefit Plan?

Locator		Instructions
12	Not Required	Patient's or Authorized Person's Signature
13	Not Required	Insured's or Authorized Person's Signature
14	Not Required	Date of Current Illness, Injury, or Pregnancy
15	Not Required	If Patient Has Had Same or Similar Illness
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	Not Required	Name of Referring Physician or Other Source
17a	Not Required	ID Number of Referring Physician - Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.
18	Not Required	Hospitalization Dates Related to Current Services
19	**Conditional**	**CLIA #**
20	Not Required	Outside Lab
21	**Required**	**Diagnosis or Nature of Illness or Injury—Enter the appropriate ICD-9-CM diagnosis, which describes the nature of the illness or injury for which the service was rendered.**
22	Not Required	SLH Resubmission
23	**Conditional**	**Prior Authorization Number - Enter the PA number for the approved service.**
24A	**Required**	**Dates of Service—Enter the From and Through dates in a two-digit format for the month, day, and year (e.g., 050103). Dates must be within the same calendar month.**
24B	**Required**	**Place of Service—Enter 22**
24C	**Required**	**Type of Service—Enter the following one-digit CMS code:** **1 Medical Care** **2 Surgery**
24D	**Required**	**Procedures** **CPT/HCPCS—Enter the five-digit CPT/HCPCS Code 99214 or the ASC, which describes the procedure rendered.**

Locator		Instructions
24E	**Required**	**Diagnosis Code—Enter the entry identifier of the ICD-9-CM diagnosis code listed in Locator 21 as the primary diagnosis. The only valid values are 1-4.**
24F	**Required**	**Charges—Enter the total usual and customary charges for the procedures/services.**
24G	**Required**	**Days or Units—Enter the number of times the procedure, service, or item was provided during the service period.**
24H	**Conditional**	**EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.**
24I	**Conditional**	**EMG (Emergency)—Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**Conditional**	**COB (Primary Carrier Information)—Enter the appropriate code.** **2 No Other Coverage (If the Carrier Code on the client's Eligibility Notification Form is blank, indicating no other coverage, enter Code 2 here.)** **3 Billed and Paid (Bill the SLH Program only if the amount paid by the primary carrier, including Medicare, is less than the charge for this service. If the provider has received payment from the primary carrier, use Code 3. Enter in Block 24K the amount paid from the primary carrier, including Medicare. Attach a copy of the primary carrier's EOB.)** **5 Billed, No Coverage (Use this code when the client has insurance coverage but the policy does not cover this particular item or service. The provider must bill the insurance carrier and receive notification of the denial of the claim. Do not use code 5 when the carrier requests further information before making the final determination).**
24K	**Conditional**	**Reserved for Local Use—Enter the dollar amount received from the primary carrier, including Medicare, if Block 24J is coded "3."**
25	Not Required	Federal Tax ID Number

Locator		Instructions
26	Optional	Patient's Account Number—Up to seventeen alpha-numeric characters are acceptable.
27	Not Required	Accept Assignment
28	Not Required	Total Charge
29	Not Required	Amount Paid
30	Not Required	Balance Due
31	**Required**	**Signature of the Physician or Supplier Including Degrees or Credentials—The provider or agent must sign and date the invoice in this block.**
32	Not Required	Name and Address of Facility Where Services Were Rendered
33	**Required**	**Physician's Supplier's Billing Name, Address, ZIP Code and Phone #—Enter the provider's billing name, address, ZIP Code, and phone number as they appear in the SLH provider record. Enter the SLH/SLH servicing provider number in the PIN # Field. Enter SLH/SLH billing provider number in the GRP # Field. Effective with claims postmarked after May 31, 2003, the provider number for SLH will be the same as Medicaid. Ensure that the provider number is distinct and separate from the phone number or ZIP Code.**

INVOICE PROCESSING

The SLH invoice processing system utilizes a sophisticated electronic system to process SLH claims. Once a claim has been received, imaged, assigned a cross reference number, and entered into the system, it is placed in one of the following categories:

Turnaround Document Letter (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to First Health. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher

- **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).

- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.

- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

TABLE OF CONTENTS

APPROVED OMB NO. 0938-0279

ST11843.1PLY.UB-92

1

2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED.TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 M-S	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a												A	A
b												B	B
												C	C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT	
a		-		-		-	a
b		-		-		-	b
c		-		-		-	c
d		-		-		-	d

	42 REV.CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						-	-		1
2						-	-		2
3						-	-		3
4						-	-		4
5						-	-		5
6						-	-		6
7						-	-		7
8						-	-		8
9						-	-		9
10						-	-		10
11						-	-		11
12						-	-		12
13						-	-		13
14						-	-		14
15						-	-		15
16						-	-		16
17						-	-		17
18						-	-		18
19						-	-		19
20						-	-		20
21						-	-		21
22						-	-		22
23						-	-		23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P. AYMENTS	55 EST. AMOUNT DUE	56	
A					-	-		A
B					-	-		B
C					-	-		C
57		DUE FROM PATIENT ▶			-	-		

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID	
83 OTHER PHYS. ID A	a
	b
OTHER PHYS. ID B	a
	b
85 PROVIDER REPRESENTATIVE X	86 DATE

84 REMARKS	
a	
b	
c	
d	

UB-92 HCFA-1450 OCR/ORIGINAL ICERTIFY THE CERTIFICATIONS ONTHE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Claim Attachment Form

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)* **M M** **D D** **C C Y Y** **Sequence Number (5 digits)**

Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

COMMENTS:_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345).

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the SLH Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the SLH ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.

General Acute Care Hospitals
Revenue Codes

Revenue Code	Description	Cost Code	Inpatient	Outpatient
0001	Total Charge		Y	Y
0100	All Inclusive Rate (R&B + Ancillary)	100	Y	N
0101	All Inclusive R & B	100	Y	N
0110	R&B-Pvt-General	110	Y	N
0111	R&B-Pvt-Med-Surg-Gyn	110	Y	N
0112	R&B-Pvt-Obstetric	110	Y	N
0113	R&B-Pvt-Pediatric	110	Y	N
0114	R&B-Pvt- Psychiatric	110	Y	N
0115	R&B-Pvt-Hospice		N	N
0116	R&B-Pvt-Detoxification		N	N
0117	R&B-Pvt-Oncology	110	Y	N
0118	R&B-Pvt-Rehabilitation	110	Y	N
0119	R&B-Pvt-Other	110	Y	N
0120	R&B-Semi-Pvt-2 Bed-General	120	Y	N
0121	R&B-2 Bed-Med-Surg-Gyn	120	Y	N
0122	R&B-2 Bed-Obstetric	120	Y	N
0123	R&B-2 Bed-Pediatric	120	Y	N
0124	R&B-2 Bed-Psychiatric	120	Y	N
0125	R&B-2 Bed-Hospice		N	N
0126	R&B-2 Bed-Detoxification		N	N
0127	R&B-2 Bed-Oncology	120	Y	N
0128	R & B-2 Bed-Rehabilitation	120	Y	N
0129	R&B-2 Bed-Other	120	Y	N
0130	R&B-3-4 Bed-General	130	Y	N
0131	R&B-3-4 Bed-Med-Surg-Gyn	130	Y	N
0132	R&B-3-4 Bed-Obstetric	130	Y	N
0133	R&B-3-4 Bed-Pediatric	130	Y	N
0134	R&B-3-4 Bed-Psychiatric	130	Y	N
0135	R&B-3-4 Bed-Hospice		N	N
0136	R&B-3-4 Bed-Detoxification		N	N
0137	R&B-3-4 Bed-Oncology	130	Y	N
0138	R & B-3-4 Bed-Rehabilitation	130	Y	N
0139	R&B-3-4 Bed-Other	130	Y	N
0140	R&B-Pvt-Deluxe-General		N	N
0141	R&B-Pvt Deluxe-Med-Surg-Gyn		N	N
0142	R&B-Pvt-Deluxe-Obstetric		N	N
0143	R&B-Pvt-Deluxe-Pediatric		N	N
0144	R&B-Pvt-Deluxe-Psychiatric		N	N
0145	R&B-Pvt-Deluxe-Hospice		N	N
0146	R&B-Pvt-Deluxe-Detoxification		N	N
0147	R&B-Pvt-Deluxe-Oncology		N	N
0148	R & B-Pvt Deluxe-Rehabilitation		N	N
0149	R&B-Pvt-Deluxe-Other		N	N

0150	R&B-Ward-General	150	Y	N
0151	R&B-Ward-Med-Surg-Gyn	150	Y	N
0152	R&B-Ward-Obstetric	150	Y	N
0153	R&B-Ward-Pediatric	150	Y	N
0154	R&B-Ward-Psychiatric	150	Y	N
0155	R&B-Ward-Hospice		N	N
0156	R&B-Ward-Detoxification		N	N
0157	R&B-Ward-Oncology	150	Y	N
0158	R & B-Ward-Rehabilitation	150	Y	N
0159	R&B-Ward-Other	150	Y	N
0160	Other R&B-General	160	Y	N
0164	Other R&B-Sterile Environment	160	Y	N
0167	Other R&B-Self Care	160	Y	N
0169	Other R&B-Other	160	Y	N
0170	Nursery-General	170	Y	N
0171	Nursery-(Level I) Normal Newborn	171	Y	N
0172	Nursery-(Level II) Premature Newborn	172	Y	N
0173	Nursery-Level III-Sick Neonate	173	Y	N
0174	Nursery Level IV-Intensive Neonate	174	Y	N
0179	Nursery-Other	179	Y	N
0180	Leave Of Absence (LOA) Gen	180	N	N
0181	LOA-Reserved		N	N
0182	LOA-Patient Convenience	182	N	N
0183	LOA-Therapeutic	183	N	N
0184	LOA-ICF-MR, Any Reason	184	N	N
0185	LOA-Nursing Home for Hospital	185	N	N
0189	LOA-Other	189	N	N
0190	Subacute Care-General		N	N
0191	Subacute Care-Level I-Skilled Care		N	N
0192	Subacute -Level II-Comprehensive C		N	N
0193	Subacute-Level-III-Complex Care		N	N
0194	Subacute-Level-IV-Intensive Care		N	N
0199	Subacute Care-Other		N	N
0200	Intensive Care (ICU)-General	200	Y	N
0201	ICU-Surgical	200	Y	N
0202	ICU-Medical	200	Y	N
0203	ICU-Pediatric	200	Y	N
0204	ICU-Psychiatric	200	Y	N
0206	ICU-Intermediate	200	Y	N
0207	ICU-Burn Care	207	Y	N
0208	ICU-Trauma	200	Y	N
0209	ICU-Other	200	Y	N
0210	Coronary Care (CCU)-General	210	Y	N
0211	CCU-Myocardial Infarction	210	Y	N
0212	CCU-Pulmonary	210	Y	N
0213	CCU-Heart Transplant	210	Y	N
0214	CCU-Intermediate	210	Y	N
0219	CCU-Other	210	Y	N
0220	Special Charges-General		N	N
0221	Special Charges-Admit Charge		N	N
0222	Special Charges-Technical Support		N	N

0223	Special Charges-U.R. Service Charge		N	N
0224	Special Charges-Late D/C, Med Nec	224	Y	N
0229	Special Charges-Other		N	N
0230	Incremental Nsg. Care Rate-Gen	230	Y	N
0231	Increm Nsg. Care Rate-Nursery	230	Y	N
0232	Increm Nsg. Care Rate-Obstetric	230	Y	N
0233	Increm Nsg. Care Rate-ICU	230	Y	N
0234	Increm Nsg. Care Rate-CCU	230	Y	N
0235	Increm Nsg. Care Rate-Hospice		N	N
0239	Increm Nsg. Care Rate-Other	230	Y	N
0240	All Inclusive Ancillary-General	240	Y	N
0241	All Inclusive Ancillary-Basic	240	Y	N
0242	All Inclusive Ancillary-Comprehensive	240	Y	N
0243	All Inclusive Ancillary-Specialty	240	Y	N
0249	All Inclusive Ancillary-Other	240	Y	N
0250	Pharmacy (Drugs)-General	250	Y	N
0251	Drugs-Generic	250	Y	N
0252	Drugs-Non-Generic	250	Y	N
0253	Drugs-Take Home	250	Y	N
0254	Drugs-Incident to Other Diagnostic S	250	Y	N
0255	Drugs-Incidental to Radiology	250	Y	N
0256	Drugs-Experimental		N	N
0257	Drugs-Non-Prescription	250	Y	N
0258	Drugs-I.V. Solutions	250	Y	N
0259	Drugs-Other	250	Y	N
0260	I.V. Therapy-General	260	Y	N
0261	I.V. Therapy-Infusion Pump	260	Y	N
0262	I.V. Therapy-Pharmacy Services	260	Y	N
0263	I.V. Therapy-Drug-Supply Delivery	260	Y	N
0264	I.V. Therapy-Supplies	260	Y	N
0269	I.V. Therapy-Other	260	Y	N
0270	Med-Surg. Supplies-General	270	Y	N
0271	Med-Surg. Supplies-Non-Sterile	270	Y	N
0272	Med-Surg. Supplies-Sterile	270	Y	N
0273	Med-Surg. Supplies-Take Home	270	Y	N
0274	Med-Surg. Suppl-Prosthetic-Orthotic	270	Y	N
0275	Med-Surg. Supplies-Pacemaker	270	Y	N
0276	Med-Surg. Supplies-Intraocular Lens	270	Y	N
0277	Med-Surg. Supplies-O2-Take Home	270	N	N
0278	Med-Surg. Supplies-Implants	270	Y	N
0279	Med-Surg. Supplies-Other	270	Y	N
0280	Oncology-General	280	Y	N
0289	Oncology-Other	280	Y	N
0290	Durable Medical Equip.-General	290	Y	N
0291	Medical Equip-Rental	290	Y	N
0292	Medical Equip-Purchase of New DME	290	Y	N
0293	Medical Equip-Purchase 0f Used DME	290	Y	N
0294	Med- Equip-Supplies/Drugs for DME Effectiveness (HH Agency Only)		N	N
0299	Medical Equip-Other	290	Y	N
0300	Laboratory (Lab)-General	300	Y	N

0301	Lab-Chemistry	300	Y	N
0302	Lab-Immunology	300	Y	N
0303	Lab-Renal Patient (Home)		N	N
0304	Lab-Non-Routine-Dialysis	300	Y	N
0305	Lab-Hematology	300	Y	N
0306	Lab-Bacteriology-Microbiology	300	Y	N
0307	Lab-Urology	300	Y	N
0309	Lab-Other	300	Y	N
0310	Pathology Lab (Path Lab)-General	310	Y	N
0311	Path Lab-Cytology	310	Y	N
0312	Path Lab-Histology	310	Y	N
0314	Path Lab-Biopsy	310	Y	N
0319	Path Lab-Other	310	Y	N
0320	Dx X-Ray-General	320	Y	N
0321	Dx X-Ray-Angiocardiography	320	Y	N
0322	Dx X-Ray-Arthrography	320	Y	N
0323	Dx X-Ray-Arteriography	320	Y	N
0324	Dx X-Ray-Chest	320	Y	N
0329	Dx X-Ray-Other	320	Y	N
0330	Therapeutic X-Ray (Rx X-Ray)-Gen	330	Y	N
0331	Rx X-Ray-Chemotherapy-Injected	330	Y	N
0332	Rx X-Ray-Chemotherapy-Oral	330	Y	N
0333	Rx X-Ray-Radiation Therapy	330	Y	N
0335	Rx X-Ray-Chemotherapy-I.V.	330	Y	N
0339	Rx X-Ray-Other	330	Y	N
0340	Nuclear Medicine (Nuc Med)-General	340	Y	N
0341	Nuclear Medicine-Diagnostic	340	Y	N
0342	Nuclear Medicine-Therapeutic	340	Y	N
0349	Nuclear Medicine-Other	340	Y	N
0350	CT Scan-General	350	Y	N
0351	CT Scan-Head	350	Y	N
0352	CT Scan-Body	350	Y	N
0359	CT Scan-Other	350	Y	N
0360	Operating Room (OR) Services	360	Y	N
0361	OR Services-Minor Surgery	360	Y	N
0362	OR Serv-Organ Trans-other than Kidn	360	Y	N
0367	OR Serv-Kidney Transplant	360	Y	N
0369	OR Services-Other	360	Y	N
0370	Anesthesia-General	370	Y	N
0371	Anesthesia-Incident to Radiology	370	Y	N
0372	Anesthesia-Incident to Other Diag	370	Y	N
0374	Anesthesia-Acupuncture		N	N
0379	Anesthesia-Other	370	Y	N
0380	Blood-General	380	Y	N
0381	Blood-Packed Red Cells	380	Y	N
0382	Blood-Whole	380	Y	N
0383	Blood-Plasma	380	Y	N
0384	Blood-Platelets	380	Y	N
0385	Blood-Leucocytes	380	Y	N
0386	Blood-Other Components	380	Y	N
0387	Blood-Other Derivatives (Cryopricipit)	380	Y	N

0389	Blood-Other	380	Y	N
0390	Blood Storage-Processing-Gen	390	Y	N
0391	Blood Storage-Administration	390	Y	N
0399	Blood Storage-Other	390	Y	N
0400	Imaging Services-General	400	Y	N
0401	Imaging Serv-Diag.-Mammography	400	Y	N
0402	Imaging Serv-Ultrasound	400	Y	N
0403	Imag Serv-Screening Mammogram	400	Y	N
0404	Imag Serv-Positron Emission Tom	400	Y	N
0409	Imaging Services-Other	400	Y	N
0410	Respiratory Services-General	410	Y	N
0412	Respir Serv-Inhalation	410	Y	N
0413	Respir Serv-Hyperbaric O2	410	Y	N
0419	Respir Serv-Other	410	Y	N
0420	Physical Therapy (P.T.)-General	420	Y	N
0421	P.T.-Visit Charge	420	Y	N
0422	P.T.-Hourly Charge	420	Y	N
0423	P.T.-Group Rate	420	Y	N
0424	P.T.-Evaluation or Re-evaluation	420	Y	N
0429	P.T.-Other	420	Y	N
0430	Occupational Therapy (O.T.)-General	430	Y	N
0431	O.T.-Visit Charge	430	Y	N
0432	O.T.-Hourly Charge	430	Y	N
0433	O.T.-Group Rate	430	Y	N
0434	O.T.-Evaluation or Re-evaluation	430	Y	N
0439	O.T.-Other	430	Y	N
0440	Speech–Language Pathology-General	440	Y	N
0441	Speech Path-Visit Charge	440	Y	N
0442	Speech Path-Hourly Charge	440	Y	N
0443	Speech Path-Group Rate	440	Y	N
0444	Speech Path-Evaluation or Re-evaluation	440	Y	N
0449	Speech–Language Path-Other	440	Y	N
0450	Emergency Room-General	450	Y	Y
0451	EMTALA-Emerg Med-Screen ServIce	450	Y	N
0452	ER Beyond EMTALA Screening	450	Y	N
0456	Urgent Care	450	N	N
0459	Emergency Room-Other	450	Y	N
0460	Pulmonary Function-General	460	Y	N
0469	Pulmonary Function-Other	460	Y	N
0470	Audiology-General	470	Y	N
0471	Audiology-Diagnostic	470	Y	N
0472	Audiology-Treatment	470	Y	N
0479	Augiology-Other	470	Y	N
0480	Cardiology-General	480	Y	N
0481	Cardiology-Cardiac Cath Lab	480	Y	N
0482	Cardiology-Stress Test	480	Y	N
0483	Cardiology-Echocardiology	480	Y	N
0489	Cardiology-Other	480	Y	N
0490	Ambulatory Surgical Care-General	490	N	Y
0499	Ambulatory Surgical Care-Other	490	N	N

0500	Outpatient Services-General	500	N	N
0509	Outpatient Services-Other	500	N	N
0510	Clinic-General	510	N	Y
0511	Clinic-Chronic Pain Center	510	N	N
0512	Clinic-Dental Clinic	510	N	N
0513	Clinic-Psychiatric	510	N	N
0514	Clinic-OB-GYN	510	N	N
0515	Clinic-Pediatric	510	N	N
0516	Clinic-Urgent Care	510	N	N
0517	Clinic-Family Practice	510	N	N
0519	Clinic-Other	510	Y	N
0520	Free-Standing Clinic-General		N	N
0521	Free-Stand Clinic-Rural Health Clinic		N	N
0522	Free-Stand Clinic-Rural Home Health		N	N
0523	Free-Stand Clinic-Family Practice		N	N
0526	Free-Stand Clinic-Urgent Care		N	N
0529	Free-Standing Clinic-Other		N	N
0530	Osteopathic Services-General	530	Y	N
0531	Osteopathic Services-Therapy	530	Y	N
0539	Osteopathic Services-Other	530	Y	N
0540	Ambulance-General		N	N
0541	Ambulance-Supplies		N	N
0542	Ambulance-Med Transport		N	N
0543	Ambulance-Heart Mobile		N	N
0544	Ambulance-Oxygen		N	N
0545	Ambulance-Air Ambulance		N	N
0546	Ambulance-Neonate		N	N
0547	Ambulance-Pharmacy		N	N
0548	Amb-Telephone Transmission EKG		N	N
0549	Ambulance-Other		N	N
0550	Skilled Nursing-General		N	N
0551	Skilled Nursing-Visit Charge		N	N
0552	Skilled Nursing-Hourly Charge		N	N
0559	Skilled Nursing-Other		N	N
0560	Medical Social Serv-General		N	N
0561	Medical Social Serv-Visit Charge		N	N
0562	Medical Social Serv-Hourly Charge		N	N
0569	Medical Social Serv-Other		N	N
0570	Home Health Aide-General		N	N
0571	Home Health Aide-Visit Charge		N	N
0572	Home Health Aide-Hourly Charge		N	N
0579	Home Health Aide-Other		N	N
0580	Other Visit-General		N	N
0581	Other Visit-Visit Charge		N	N
0582	Other Visit-Hourly Charge		N	N
0589	Other Visit-Other		N	N
0590	Home Health-Units of Serv-General		N	N
0599	Home Health-Units of Service-Other		N	N
0600	Oxygen (O2) (HH)-General		N	N
0601	O2 (HH)-State-Equip-Supply-Cont		N	N
0602	O2 (HH)-State-Equip-Supply-<1 lpm		N	N

0603	O2 (HH)-State-Equip-Suppy->4 lpm		N	N
0604	Oxygen (HH)-Portable-Add-on		N	N
0609	Oxygen, Home Health-Other		N	N
0610	Magnetic Resonance Technology	610	Y	N
0611	MRI-Brain (Including Brainstem)	610	Y	N
0612	MRI-Spinal Cord (Including Spine)	610	Y	N
0613	Reserved		N	N
0614	MRI-Other	610	Y	N
0615	MRA-Head and Neck	610	Y	N
0616	MRA-Lower Extremities	610	Y	N
0617	Reserved		N	N
0618	MRA-Other	610	Y	N
0619	MRT-Other	610	Y	N
0621	Med-Sur-Sup-Incident Radiology	620	Y	N
0622	Med-Sur-Sup-Incident-Other Diagnostic	620	Y	N
0623	Med-Sur-Sup-Surgical Dressings	620	Y	N
0624	Med-Sur-Sup-FDA Invest Device		N	N
0630	Pharmacy Extension-Reserved		N	N
0631	Pharmacy-Single Source Drug	630	Y	N
0632	Pharmacy-Multiple Source Drug	630	Y	N
0633	Pharmacy-Restrictive Prescription	630	Y	N
0634	Pharmacy-EPO-less than 10,000 Units	630	Y	N
0635	Pharmacy-EPO-10,000 Units or more	630	Y	N
0636	Pharmacy-Requiring Detailed Coding	630	Y	N
0637	Pharmacy-Self-administrable	630	Y	N
0640	Home (H) I.V.Therapy-General		N	N
0641	H-IV Therapy-Cent. Line-non-rout		N	N
0642	H-IV Therapy-Site Care-Cent line		N	N
0643	H- IV Therapy-IV Start-Chg-Peri li		N	N
0644	H-IV Therapy-Periph Line-non-rou		N	N
0645	H-IV Therapy-Train-Pat/CareGiv-CL		N	N
0646	H-IV Therapy-Train-Disabled Pt.-CL		N	N
0647	H-IV Therapy-Train-Pat/CareGiv-PL		N	N
0648	H-IV Therapy-Train-Disabled Pt.-PL		N	N
0649	H-IV Therapy-Other		N	N
0650	Hospice Services-General		N	N
0651	Hospice Serv-Routine-Home Care		N	N
0652	Hospice Serv-Continuous Home Care		N	N
0653	Hospice Services-Reserved		N	N
0654	Hospice Services-Reserved		N	N
0655	Hospice Serv-Inpatient Respite Care		N	N
0656	Hospice Serv-General Inpatient Care		N	N
0657	Hospice Serv-Physician Services		N	N
0659	Hospice Serv-Other Hospice		N	N
0660	Respite Care (HHA only)-General		N	N
0661	Respite Care-Hourly Chg-Skill Nsg		N	N
0662	Respite Care-Hourly Chg-HH Aide		N	N
0663	Respite Care-Daily Charge		Y	N
0669	Respite Care-Other		N	N
0670	Outpt Special Resid Chg-General		N	N
0671	Outpt Special Resid-Hosp Based		N	N

0672	Outpt Special Resid-Contracted		N	N
0679	Outpt Special Resid Chg-Other		N	N
0680	Trauma Response Not Used		N	N
0681	Trauma Response - Level I		N	N
0682	Trauma Response - Level II		N	N
0683	Trauma Response - Level III		N	N
0684	Trauma Response - Level IV		N	N
0689	Trauma Response - Other		N	N
069X	Not Assigned		N	N
0700	Cast Room-General	700	Y	N
0709	Cast Room-Other	700	Y	N
0710	Recovery Room-General	710	Y	N
0719	Recovery Room-Other	710	Y	N
0720	Labor Room-Delivery-General	720	Y	N
0721	Labor-Delivery-Labor	720	Y	N
0722	Labor Delivery-Delivery	720	Y	N
0723	Labor Delivery-Circumcision	720	Y	N
0724	Labor Delivery-Birthing Center	720	Y	N
0729	Labor Delivery-Other	720	Y	N
0730	EKG-ECG-General	730	Y	N
0731	EKG-ECG-Holter Monitor	730	Y	N
0732	EKG-ECG-Telemetry	730	Y	N
0739	EKG-ECG-Other	730	Y	N
0740	EEG-General	740	Y	N
0749	EEG-Other	740	Y	N
0750	Gastro-Intestinal Services-General	750	Y	N
0759	Gastro-Intestinal Services-Other	750	Y	N
0760	Treatment-Observation Room-General	760	Y	N
0761	Treatment Room	760	Y	N
0762	Observation Room	760	Y	N
0769	Treatment Room-Observation-Other	760	Y	N
0770	Preventive Care Services-General		N	N
0771	Prevent Care Serv-Vaccine Admin	771	Y	N
0779	Preventive Care Services-Other		N	N
0780	Telemedicine-General	780	Y	N
0789	Telemedicine-Other		Y	N
0790	Lithotrispy-General	790	Y	N
0799	Lithotripsy-Other	790	Y	N
0800	Inpat-Renal Dialysis-General	800	Y	N
0801	Inpatient Dialysis-Hemodialysis	800	Y	N
0802	Inpatient Dialy-Peritoneal-Non-CAPDs	800	Y	N
0803	Inpatient Dialysis-CAPD	800	Y	N
0804	Inpatient Dialysis-CCPD	800	Y	N
0809	Inpatient Dialysis-Other	800	Y	N
0810	Organ Acquisition-General	810	Y	N
0811	Organ Acquisition-Living Donor	810	Y	N
0812	Organ Acquisition-Cadaver Donor	810	Y	N
0813	Organ Acquisition-Unknown Donor	810	Y	N
0814	Unsuccessful Organ Search-	810	Y	N
0819	Organ Acquis-Other Donor	810	Y	N
0820	Hemodialysis Outpt or Home-General	820	N	N

0821	Hemodia-Opt or Home-Composite rate	820	N	N
0822	Hemodia-Opt or Home-Supplies	820	N	N
0823	Hemodia-Opt or Home-Equipment	820	N	N
0824	Hemodia-Opt or Home-Maint-100%	820	N	N
0825	Hemodia-Opt or Home-Supp Servic	820	N	N
0829	Hemodia-Opt or Home-Other	820	N	N
0830	Peritoneal Opt or Home-General	830	N	N
0831	Peritoneal Opt or Home-Composite	830	N	N
0832	Peritoneal Opt or Home-SupplieS	830	N	N
0833	Peritoneal Opt or Home-Equipment	830	N	N
0834	Peritoneal Opt or Home-Maint-100%	830	N	N
0835	Peritoneal Opt or Home-Suppt Servi	830	N	N
0839	Peritoneal Opt or Home-Other	830	N	N
0840	CAPD Opt or Home-General	840	N	N
0841	CAPD Opt or Home-Composite Rate	840	N	N
0842	CAPD Opt or Home-Supplies	840	N	N
0843	CAPD Opt or Home-Equipment	840	N	N
0844	CAPD Opt or Home-Maint-100%	840	N	N
0845	CAPD Opt or Home-Support Service	840	N	N
0849	CAPD Opt or Home-Other	840	N	N
0850	CCPD Opt or Home-General	850	N	N
0851	CCPD Opt or Home-Composite Rate	850	N	N
0852	CCPD Opt or Home-Home Supplies	850	N	N
0853	CCPD Opt or Home-Equipment	850	N	N
0854	CCPD Opt or Home-Maint-100%	850	N	N
0855	CCPD Opt or Home-Support Services	850	N	N
0859	CCPD Opt or Home-Other	850	N	N
086X	Reserved for Dialysis-National Assign		N	N
087X	Reserved for Dialysis-National Assign		N	N
0880	Dialysis-Miscellaneous-General	880	Y	N
0881	Dialysis-Miscell-Ultrafiltration	880	Y	N
0882	Dialysis-Miscell-Home Dialy Aide Vis	880	N	N
0889	Dialysis-Miscellaneous-Other	880	Y	N
089X	Reserved for National Assignment		N	N
0900	Psychiatric/Psycholog Treat-General	900	Y	N
0901	Psych/Psycho Treat-Electroshock	900	Y	N
00902	Psych/Psycho Treat-Milieu Ther	900	Y	N
0903	Psych/Psycho Treat-Play Therapy	900	Y	N
0904	Psych/Psycho Treat-Activity Ther	900	Y	N
0909	Psych/Psycho Treatment-Other	900	Y	N
0910	Psych/Psycho Services-General	910	Y	N
0911	Psych/Psycho Serv-Rehabilitation	910	N	N
0912	Psych/Psycho Serv-Partial Hosp.	910	N	N
0913	Psych/Psycho Serv-Part-Hosp-Intens	910	N	N
0914	Psych/Psycho Serv-Individual Therapy	910	Y	N
0915	Psych/Psycho Serv-Group Therapy	910	Y	N
0916	Psych/Psycho Serv-Family Therapy	910	Y	N
0917	Psych/Psycho Serv-Bio Feedback		N	N
0918	Psych/Psycho Serv-Testing	910	Y	N
0919	Psych/Psycho Serv-Other	910	Y	N
0920	Other Diagnostic Serv-General	920	Y	N

0921	Other Diag. Serv-Peripheral-Vas-Lab	920	Y	N
0922	Other Diag. Serv-EMG	920	Y	N
0923	Other Diag. Serv-Pap Smear	920	Y	N
0924	Other Diag. Serv-Allergy Test	920	Y	N
0925	Other Diag. Serv-Pregnancy Test	920	Y	N
0929	Other Diag. Serv-Other	920	Y	N
0931	Medical Rehab Day - Half Day		N	N
0932	Medical Rehab Day - Full Day		N	N
0940	Other Therapeutic Serv-General	940	Y	N
0941	Other Therap Serv-Recreational Therap		N	N
0942	Other Therap Serv-Education-Training		N	N
0943	Other Therap Serv-Cardiac Rehab	940	Y	N
0944	Other Therap Serv-Drug Rehab		N	N
0945	Other Therap Serv-Alcohol Rehab		N	N
0946	Other Therap Serv-Complex Medical Equipment-Routine	940	Y	N
0947	Other Therap Serv-Complex Medical Equipment-Ancillary	940	Y	N
0949	Other Therapeutic Services-Other	940	Y	N
0950	Other Therap Services- Reserved		N	N
0951	Athletic Training		N	N
0952	Kinesiotherapy		N	N
0960	Professional Fees-General		Transplants only	N
0961	Prof Fees-Psychiatric		N	N
0962	Prof Fees-Opthalmology		N	N
0963	Prof Fees-Anesthesiology (MD)		N	N
0964	Prof Fees-Anesthetist (CRNA)		N	N
0969	Prof Fees-Other Prof. Fees		N	N
0970	Professional Fees-General-Delete		N	N
0971	Professional Fees-Laboratory		N	N
0972	Prof Fees-Radiology-Diagnostic		N	N
0973	Prof Fees-Radiology-Therapeutic		N	N
0974	Prof Fees-Radiology-Nuclear Med		N	N
0975	Prof Fees-Operating Room		N	N
0976	Prof Fees-Respiratory Therapy		N	N
0977	Prof Fees-Physical Therapy		N	N
0978	Prof Fees-Occupational Therapy		N	N
0979	Prof Fees-Speech Pathology		N	N
0981	Prof Fees-Emergency Room		N	N
0982	Prof Fees-Outpatient Services		N	N
0983	Prof Fees-Clinic		N	N
0984	Prof Fees-Medical Social Services		N	N
0985	Prof Fees-EKG		N	N
0986	Prof Fees-EEG		N	N
0987	Prof Fees-Hospital Visit		N	N
0988	Prof Fees-Consultation		N	N
0989	Prof Fees-Private Duty Nurse		N	N
0990	Patient Convenience Item-General		N	N
0991	Patient Conven Item-Caféteria/Guest		N	N
0992	Patient Conven Item-Pvt-Linen Service		N	N

0993	Patient Conven Item-Phone-Telegraph		N	N
0994	Patient Conven Item-TV-Radio		N	N
0995	Patient Conven Item-Non-Pat.Rm Rent		N	N
0996	Patient Conven Item-Late Discharge		N	N
0997	Patient Conven Item-Admission Kits	997	Y	N
0998	Patient Conven Item-Barber-Beauty		N	N
0999	Patient Conven Item-Other		N	N
100X to	Reserved National Assignment			
209X	Reserved National Assignment			
2100	Alternative Therapy - General		N	N
2101	Alternative Therapy- Acupuncture		N	N
2102	Alternative Therapy- Accupressure		N	N
2103	Alternative Therapy- Massage		N	N
2104	Alternative Therapy- Reflexology		N	N
2105	Alternative Therapy-Biofeedback		N	N
2106	Alternative Therapy- Hynosis		N	N
2109	Alternative Therapy- Other		N	N
211X to	Reserved National Assignment			
300X	Reserved National Assignment			
3100	Adult Care - Not Used		N	N
3101	Adult Care -Medical & Social, Hourly		N	N
3102	Adult Care -Social, Hourly		N	N
3103	Adult Care -Medical & Social, Daily		N	N
3104	Adult Care - Social, Daily		N	N
3105	Adult Foster Care - Daily		N	N
3109	Adult Care - Other		N	N
311X thru	Reserved National Assignment			
999X	Reserved National Assignment			